Department of Community Health

1. Currently, mental health, physical health, and public health services are administered by one state department. Do you think that is the best way to organize these services? If not, what changes do you recommend?

2. In the near term, the state is facing a situation where it is spending more than it is receiving in revenues. Please outline your budget priorities for your department.

3. Michigan has been a national leader in the number of residents covered by some type of health insurance. Still, more than 10 percent of the state's population does not have health coverage and, therefore, lacks access to health care. How would you address this problem?

4. Blue Cross and Blue Shield of Michigan (BCBSM) provides insurance coverage or administrative services for more than 50 percent of Michigan's population -- 4.8 million subscribers. During the last decade, there has been a national trend among Blue plans to consolidate and some plans have converted to for-profit status. Last year, Michigan enacted a law that prohibits BCBSM from being converted to a for-profit company. In light of this national trend, and following an audit that revealed developing problems for BCBSM, Governor Engler called for reform of BCBSM in three areas: regulatory reform, board of directors reform, and small group market reform. What is your assessment of BCBSM? What do you recommend to assure that it can continue to fulfill its mission as the state's insurer of last resort?

5. Nearly 10 percent of the state's population depends on Medicaid for their health care and long-term care. Without significant changes, it is projected that in Fiscal Year 2004 there will be a $560 million Medicaid General Fund shortage. What strategies do you recommend for addressing this problem?

6. Nationally, the State of Michigan is recognized as a leader in Medicaid reform strategies. The pharmaceutical best practices initiative is one example of this state's innovative approach to restraining Medicaid costs. How would you build on this foundation? What changes, if any, would you make?

7. During the last decade, tremendous progress was made toward strengthening the state's community mental health system. As a result, many recipients avoided being institutionalized and many others were able to leave institutions and return to their communities. What is your assessment of the state's mental health system today? What would you recommend to improve these services?

8. When Northville Psychiatric Hospital closes in 2003, the state will continue to operate three psychiatric hospitals for adults (Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital) plus one facility for children (the Hawthorne Center in Northville). What is your assessment of mental health resources in Michigan? Do we have the right number of inpatient psychiatric beds? Would you move forward with plans to close Northville? If not, what are your recommendations for assuring access to inpatient psychiatric care?

9. In June of 2000, Michigan's Long-Term Care Work Group issued recommendations for redesigning the state's long-term care system. The guiding principles in their recommendations were to make quality of care the top priority, enable individuals to take personal responsibility for their care, and enable people to live independently. The Office on Aging has funded several pilot projects and planning grants to improve long-term care. What steps would you take to continue this process?

10. The Elder Prescription Insurance Coverage (EPIC) program was initiated by the Senate to provide prescription drug coverage for low-income senior citizens. The Legislature also appropriated $50 million, primarily Tobacco Settlement revenue, to fund this program. Enrollment was to occur in three stages to assure access to those most in need. The first two groups have been enrolled, but the final stage of open enrollment has yet to occur. What plans do you have to complete the implementation of EPIC or to change this program?

11. Homeland Security continues to be a top priority. A number of states have revised their public health codes to assure that public health officials have sufficient authority to carry-out their responsibilities during public health emergencies. Does the Michigan Public Health Code need to be revised to assure that it serves homeland security? What role should the department play during a state of emergency?

Janet Olszewski's Senate Confirmation Questions /Responses

1.Q. Currently, mental health, physical health, and public health services are administered by one state department. Do you think that is the best way to organize these services? If not, what changes do you recommend?

1. I do believe that having mental health, public health and physical health programs within the same state department is a beneficial way to organize state services because it enhances our ability to address people's needs in a more holistic manner. It allows opportunities to reduce overlap, to achieve administrative efficiencies, and to more closely coordinate service programs. That being said, I also believe it is very important to not lose the individual focus that each of the areas must have. Public health, mental health and the Medicaid programs each have their unique mission and function and must be visible parts of the state government structure. Governor Granholm, in her platform, has signaled her intention to create a position of Surgeon General for the state of Michigan. That position will be housed within the Department of Community Health and will lead the public health activities of the Department. I will also restructure the Department to return to discreet organizational units for Mental Health and Medicaid. The Mental Health and Medicaid units will be led by Deputy Director level individuals to reinforce my commitment to clear lines of responsibility and accountability for programs.

2.Q. In the near term, the state is facing a situation where it is spending more than it is receiving in revenues. Please outline your budget priorities for your department.

2. The FY'03 appropriation for the Department of Community Health totals $9.2 billion. Of that amount $2.5 billion, or 27% are general fund dollars, and the majority of these funds are revenues we use as match for federal funds. As we develop our FY'04 budget one of my priorities will be to preserve and to the extent possible, to increase the federal revenues supporting programs operated through the Department. Nevertheless, the size of the General Fund budget shortfall will require us to carefully review every activity of the Department and the programs it funds. We will carefully review our programs and administrative funding against the Administration's priorities as well as statutory requirements and determine our budget recommendation. In doing so we must work to preserve the essential functions of our major programmatic areas; Medicaid, mental health and substance abuse programs, and public health, and must carefully evaluate the effectiveness of current approaches in creating value for consumers.

3.Q. Michigan has been a national leader in the number of residents covered by some type of health insurance. Still, more than 10 percent of the state's population does not have health coverage and, therefore, lacks access to health care. How would you address this problem?

3. I believe that access to health care incorporates two components: health insurance coverage and availability of providers and services. Without health insurance a person is limited in their use of the available health care resources until they become ill and require emergency care and hospitalization, this is an ineffective and expensive approach. No one strategy is going to solve the problem of the uninsured. I would like to see us continue the expansion of the one third share coverage programs that several counties have implemented. This will require action by the federal government to increase our Medicaid DSH ceiling so that we can obtain federal match on local funds. We are also exploring the options we have as a state to extend prescription drug coverage to non Medicaid beneficiaries. I also believe it is essential that we review the possibilities for insurance reform in this state, especially small market reform. Small employers, in particular, are having difficulty continuing their coverage for employees in the face of more than 30% increase in health insurance premiums. Michigan is one of only two or three states that have not reformed its small market insurance laws since the passage of HIPAA in 1996. It is time that we take a serious look at what we can do to promote coverage of employees who work in small companies.

However, it is also true that health insurance coverage is no guarantee of the ability to receive care. Many parts of Michigan have a shortage of physicians, nurses and other health care providers. Therefore, I believe it is critical for the department to work on both components of the access problem. The federal government is making significant appropriations available to local communities to establish community health centers. The Department has an important role to play in the application process and we have identified a unit within the Department to help communities with the process. Furthermore, we will aggressively review the existing health professions shortage designation process and determine if we are adequately supporting the designation process that allows communities to benefit from several federal programs that support the location of health practitioners in under served areas.

Finally, I have committed to having the Department of Community Health join and actively participate in the Access to Care Coalition, a broad partnership of payers and providers dedicated to finding solutions to the problems of the uninsured. Through partnerships such as this one we can identify reasonable approaches to maintaining and increasing coverage and then act on them.

4.Q. Blue Cross and Blue Shield of Michigan (BCBSM) provides insurance coverage or administrative services for more than 50 percent of Michigan's population – 4.8 million subscribers. During the last decade, there has been a national trend among Blue plans to consolidate and some plans have converted to a for-profit company. In light of this national trend, and following an audit that revealed developing problems for BCBSM, Governor Engler called for reform of BCBSM in three areas:

regulatory reform, board of directors reform, and small group market reform. What is your assessment of BCBSM? What do you recommend to assure that it can continue to fulfill its mission as the state's insurer of last resort?

4. The Insurance Commissioner and the Attorney General are, by law, the regulators for Blue Cross Blue Shield of Michigan. The Department of Community Health's role in the Blue Cross discussion is to look at the entire picture of health care delivery and financing in this state and to, with BCBSM, articulate their central role in providing access to affordable coverage. More than 180,000 senior citizens in this state have Medigap coverage through BCBSM. Over the past ten years the Department, through the Office of Services to the Aging and the Attorney General, have saved seniors at least $110,000,000 in subscriber premiums through aggressive oversight of the rate setting process. Blue Cross is the most affordable Medigap alternative in the state at this time. This is becoming even more critical as HMOs, whose premiums were often less expensive, are finding that they are unable to continue in the Medicare + Choice program. I believe it is important for the Department of Community Health to continue its advocacy role regarding coverage for individuals and senior citizens.

   Small employers struggle as their Blue Cross premiums increase 20-30%. The plight of small groups needs to be addressed as it impacts the business climate in this state: we need to engage with BCBSM HMOs and other insurers to developing solutions to the problems of health insurance for small groups. Work was begun in the last legislative session and we must continue this, not only at their business, but the business of the state. Only then can they and the state realize their mandate to promote an appropriate distribution of health care services for all residents of this state.

   In forwarding the opinion to the legislature regarding for-profit conversion of BCBSM, Attorney General Granholm cited another important point that is worth repeating here. She stated: the most recent legislative reform of BCBSM, 1990 PA 350, reflects reform that was accomplished through a truly remarkable, broad-based coalition of interest groups, consumers, and agencies of state government. Whether its the question of for-profit conversion, small group business or individual Medigap rate increases, board of directors reform or the other important issues of regulatory reform, it is critical that we return to the broad-based coalition model when addressing these questions. I would urge us to use such a coalition to address issues regarding BCBSM.

5.Q. Nearly 10 percent of the state's population depends on Medicaid for their health care and long-term care. Without significant changes, it is projected that in Fiscal Year 2004 there will be a $560 million Medicaid General Fund shortage. What strategies do you recommend for addressing this problem?

5. Addressing the Medicaid funding issues will require a combination of short and long term strategies. We must find ways to reduce spending and increase revenues quickly in order to balance the FY'03 budget. However, we must also begin to develop a framework to restructure the Medicaid program so that it can meet its goal of providing health care coverage for our most vulnerable citizens within a budget structure that can be sustained long term. Given the Medicaid program operates under significant federal statutory and regulatory requirements the restructuring of the program requires federal intervention and will take some time to complete.

Before we address reductions to the program, we must first assure that we are using all available federal revenues. To this end the previous administration and this Legislature adopted a Quality Assurance Assessment Program for hospitals, nursing homes and health plans. These initiatives, once approved by the federal government will bring $167 million additional dollars to the state. I will work aggressively to complete the work of getting approval from CMS to implement the programs. These funds will be used to stabilize provider funding as well as address the shortfall.

Michigan has also successfully implemented a very aggressive program of supplemental rebates on Medicaid prescription drugs to lower prescription drug costs. We hope to build on this by developing multi state arrangements that increase volume and therefore afford us larger rebates for our pharmacy program and to look at other approaches to further improve our drug spending within the Medicaid program.

On January 13, the Kaiser Commission on Medicaid and the Uninsured released a survey of the 50 states that indicated 49 states have either already cut Medicaid spending or plan to do so this year. Essentially, Medicaid is a three-legged stool. The three components of the program are eligibility, benefits and provider payments. As we face the need to reduce expenditures, we have to look at each of the three components. Historically, payment rates to providers have not been generous and are approaching critical levels. Therefore, we, like other states, will have no choice but to also look to modify structure and eligibility groups currently covered under the program.

There are no easy answers to this question nor are there any good choices. Anything we do will cause pain and dislocation. Consequently, Governor Granholm has engaged the entire health care community in a dialogue about how best to move forward with the Medicaid program through the Medicaid Summit she convened on November 21, 2002, and the subsequent two rounds of organized input. The second round of comments were completed on January 15. We are now in the process of synthesizing those comments

and ideas and determining what directions we should explore. While I cannot provide details at this time, I look forward to discussing our proposals with the Legislature during the coming months.

6.Q. Nationally, the State of Michigan is recognized as a leader in Medicaid reform strategies. The pharmaceutical best practices initiative is one example of this state's innovative approach to restraining Medicaid costs. How would you build on this foundation? What changes, if any, would you make?

6. I wholeheartedly agree with your assessment that Michigan has been a leader in Medicaid reform strategies and would like to recognize that many individuals inside and outside state government contributed to this distinction. Certainly, our Medicaid pharmacy program is an example of such creativity. I would expect us to build on this foundation by expanding our supplemental rebate agreements to a multi state approach and by exploring ways to offer our Medicaid pricing to other low income individuals. As I indicated in the previous answer we have solicited input from a very broad group of individuals and organizations through the Medicaid Summit process. We have received many ideas and are now sorting and researching which have the most promise. Furthermore, we will actively work with the National Governors Association, the Michigan Congressional delegation and others to promote federal action to allow states more flexibility in designing and operating their Medicaid programs.

7.Q. During the last decade, tremendous progress was made toward strengthening the state's community mental health system. As a result, many recipients avoided being institutionalized and many others were able to leave institutions and return to their communities. What is your assessment of the state's mental health system today? What would you recommended to improve these services?

7. Michigan's public mental health system is viewed nationally as one of the most progressive and functional of any state mental health system.

However, there are still gaps and emerging problem areas within our mental health system:

_ Having made the jump from institutional care to community-based programs, the system is undergoing still another modification, from community programs to consumer-centered and directed service and support models. The Mental Health Code revisions of 1996 codified the use of person-centered planning as a requirement within the system, and the Medicaid managed specialty services program made possible new and innovative

service and support options. However, the mental health system has not fully realized the promise inherent in these changes, and more remains to be done. Person-centered planning underscores the fact that life and successful living should be the central aim of a system of mental health services and supports. We must promote programmatic approaches that foster independence.

_ Too many individuals with mental illnesses or substance abuse problems and children with emotional disorders end-up in our jails and juvenile correction facilities, and effective models for diversion, alternative disposition and follow up care have not been widely disseminated or fully implemented.

_ Prevention and early intervention initiatives for children, adolescents and vulnerable adult populations have lost ground.

_ Coordination between the mental health system and community-based health and human services system should to be strengthened, particularly in regard to children, adolescents and families.

_ The early retirement program has meant the exodus of some of the most experienced staff at our hospitals and centers, and the current budgetary situation constrains the department's ability to appropriately staff state facilities.

_ Persons with mental illnesses and individuals with developmental disabilities have difficulty moving from residential group homes to independent living arrangements, due to the lack of affordable supported housing.

We are moving into an era where the degree of government support for mental health services will be more severely constrained than it has ever been before. During the past decade, mental health services have been supported, for the most part, at a constant funding level. During this same period, costs have increased. This has resulted in a reduction in the purchasing power of each local entity's financing base. Some of this lost financial capacity has been addressed by creating new approaches to serving the same general population of individuals.

However, we are also experiencing an increase in demand and this will not cease simply because we attempt to curtail access. On the developmental disabilities side, we know that for each person who is served locally with residential and rehabilitative supports, there are many others - - adults - - who are living at home with relatives. These individuals are not the legal responsibility of their parents once they turn age 18, but in fact their parents are providing for their housing, their meals, and their support needs. These parent care givers are aging, and as they age, they become unable to continue to provide care for their son or daughter. Some estimates place these numbers at levels that are significantly larger than the number of individuals who are already in the "system." Many CMH Services Programs are experiencing the effect of this process, and wondering how much more unmet demand might be coming their way.

In the arena of mental illness, the demands placed upon the system are very much related to the economy. When the economy is good, the level of stress upon our citizens that results from experiences such as joblessness, marital discord, drug and alcoholism, and so on, is less. But we know that demand for hospitalization increases sharply as a recession continues. Even as the economy recovers we will see demand increase, since the stresses that can culminate in a mental health emergency take some time to reach the point that outside intervention becomes necessary. Our capacity to respond to these basic needs of the citizens of Michigan has been good, to this point. But the near term poses many complexities that will affect our ability to continue to adequately respond.

What would you recommend to improve these services?

Obviously, maintaining and enhancing the funding base for public mental health services in Michigan is essential to continuing to evolve the system in directions it needs to go, but our current budget situation may precludes this option for at least a year or two.

It cannot be stated too strongly that our mental health and substance abuse services systems must redouble its efforts to address and respond to those with mental illness and substance abuse who become caught up in the criminal justice system. Some of the factors that affect this involve housing, jobs, support from family and friends other aspects of living that are far from the control of those in mental health. But in each local

community, there must be a continued and renewed focus on cooperative efforts between law enforcement and the courts, local CMH Services Programs, and substance abuse programs.

Closely related to this is the matter of just how much hospital bed capacity needs to exist in our public mental health system. Experiences tell us that many of the ongoing needs of mental health consumers can be better met through supportive, community-based methodologies, and that when these options are easily available and properly tailored, the need for long-term hospital care is reduced, possibly eliminated. But we also know that hospitals are necessary for some individuals, and for some of these individuals their dependence on a hospital setting can persist beyond a simple short-term stay. I want to gather more detail on what, exactly, we need for now and for the foreseeable future in the way of hospital beds. I am not certain that we have looked at this with the sort of precision we should be applying to this set of problems. But at the same time, I want to see us strengthen our supportive and technical guidance to CMH Services Programs so that their proficiencies in addressing the population of individuals with severe and persistent mental illness can improve.

Our system has taken some steps to include consumers and family members at the table when policy is being deliberated and programs evaluated. I believe that we have only begun to learn what it is we need to do to focus on consumers and strengthen a meaningful partnership with them. Not only must we reaffirm the principles of person-centered planning, we must understand that the pursuit of person-centered planning is a route to the assumption, on the part of each individual served, of responsibility for his or her life. Michigan has developed, within several CMH Services Programs, the capacity to support individuals and families who have taken on the responsibility for directly selecting and controlling the delivery of services. We need to continue and expand these efforts.

8.Q. **When Northville Psychiatric Hospital closes in 2003, the state will continue to operate three psychiatric hospitals for adults (Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital) plus one facility for children (the Hawthorne Center in Northville). What is your assessment of mental health resources in Michigan? Do we have the right number of inpatient psychiatric beds?**

Would you move forward with plans to close Northville? If not, what are your recommendations for assuring access to inpatient psychiatric care?

8. Based upon current census and admission/discharge trends, the department has an adequate number of state hospital beds to meet demand. If admissions should rise and/or length of stay in state facilities should increase, there are opportunities to expand capacity at the remaining psychiatric hospitals for adults, to address these conditions. We currently have 653 adults in hospitals and have capacity for 731 patients. Additionally, Hawthorn Center has a current census of 44 children with a capacity to serve 118 and Mt. Pleasant Center has a census of 162 developmentally disabled patients with a capacity of 229. In addition to the state hospital beds, there are numerous psychiatric beds available throughout the state in community hospitals that have psychiatric units.

It is difficult to assess whether we have the "right" number of inpatient psychiatric beds. Demand for and the use of state hospital inpatient treatment has steadily declined over the past decade. The Olmstead decision reinforces our need to serve individuals in the community whenever possible. Community inpatient treatment has emerged as an alternative to state-hospital use, although these units generally provide only acute care. Finally, community-based treatment options have increased significantly.

A number of organizations and advocacy groups have voiced concerns that the state lacks sufficient capacity to provide "long-term" inpatient psychiatric hospital care for certain patients who have difficult or refractory conditions. They point to the increases in the number of adults and children with mental illness in our jails and juvenile correction facilities.

As I indicated in my response to Question 7, I believe we should look at the question of inpatient long-term care to determine the best approach to providing the care individuals need while conserving taxpayer resources.

I believe that we must move forward with the closing of Northville. The early retirement program has exacerbated staffing problems. There are also some pressing physical plant issues at Northville that cannot be easily remedied. Census at the facility has steadily

dropped over the past 10 months, and this reduced utilization has hastened the need to close the facility and consolidate operations at the remaining hospitals. The current censes at Northville is 227 patients.

9.Q. **In June of 2000, Michigan's Long-Term Care Work Group issued recommendations for redesigning the state's long-term care system. The guiding principles in their recommendations were to make quality of care the top priority, enable individuals to take personal responsibility for their care, and enable people to live independently. The Office of Aging has funded several pilot projects and planning grants to improve long-term care. What steps would you take to continue this process?**

In 2001, DCH funded 48 Long-Term Care innovation grants. Many of these grants are now winding down, and I have not yet had the opportunity to review their outcomes. However, with the state budget under severe strain, expenditures on Long Term Care (LTC) continuing to climb, and the growth in elderly and disabled Medicaid beneficiaries, I will be looking to these programs for ideas that can be replicated without the commitment of new funds or DCH staff resources to improve quality, increase independence, and heighten personal responsibility.

Long-Term Care represents a significant portion of the Medicaid program and we must address it as part of the Medicaid restructuring process. It will be necessary to weigh the value of any new ventures very carefully. Our first responsibility is to maintain a strong and flexible LTC safety net for our poorest, most disabled and most vulnerable citizens. That safety net must include choices for consumers about where and how services and supports are provided. Furthermore, DCH must redouble its efforts to purchase the highest quality care available, across all LTC settings. The information system investments DCH made during the last decade will play a critical role in helping the department identify and invest in the highest quality, most responsive safety net that we can afford, given our budget strictures. I look forward to sharing more specific ideas with you as we develop our Medicaid restructuring proposals.

10.Q. The Elder Prescription Insurance Coverage (EPIC) program was initiated by the Senate to provide prescription drug coverage for low-income senior citizens. The Legislature also appropriated $50 million, primarily Tobacco Settlement revenue, to fund this program. Enrollment was to occur in three stages to assure access to those most in need. The first two groups have been enrolled, but the final stage of open enrollment has yet to occur. What plans do you have to complete the implementation of EPIC or to change this program?

10. The Elder Prescription Insurance Coverage (EPIC) program is currently providing prescription coverage to approximately 15,000 persons. As you know, these individuals are Michigan residents who had previously received a prescription benefit through the Michigan Emergency Prescription Program for Seniors (MEPPS) or had received a tax credit during the previous tax year. Enrollment for both of these groups was completed in January 2002. The previous administration determined that before the program could be expanded beyond these two groups, DCH needed to develop a cost history on the individuals enrolled in EPIC, to assure that expenditures would not exceed the appropriation. Currently, EPIC program expenditures are $26 million annually. We have seen lower enrollment for the first two groups than expected and at this time do not have a complete understanding of why intended enrollment did not occur.

While, the program has lapsed funds, DCH did not implement open enrollment for two reasons during FY-02. The first was the announcement of the Pharmacy Plus Program in the spring of 2002 by President Bush. This program provides federal matching funds for programs such as EPIC through a Medicaid waiver. While the announcement was considered good news, the Department also expressed a concern surrounding a possible Maintenance Of Effort (MOE) requirement. It was unclear whether or not there would be a MOE applied to states that had existing senior pharmacy programs. Michigan did not want to expand the program to the $50 million level and then be required to maintain this level of MOE. The second reason for not expanding enrollment in the EPIC program was the uncertainty of Proposal A, which could have removed the tobacco settlement funding from EPIC, forcing a reduction in the program.

The FY-03 appropriation for the EPIC program assumes implementation of a Pharmacy Plus waiver plus additional federal revenues for an expanded pharmacy program that has

not been introduced in Congress. The gross appropriation for the EPIC program with the Pharmacy Plus waiver is $49.8 million, with tobacco settlement funding of $22 million. The department continues to explore the Pharmacy Plus waiver program as well as other options to expand prescription coverage for the senior citizens of Michigan. We want to assess the EPIC Program in the context of an overall prescription drug assistance strategy. The department is also currently exploring options that may be available to lower the cost of prescriptions to Michigan's seniors by taking advantage of its purchasing power. However, the decision in Federal Court on the PhARMA lawsuit against the Secretary of Health and Human Services will have an effect on the State of Michigan's ability to move forward with the expansion of pharmacy initiatives. However, until we secure federal revenues, the department will be unable to expand the program through an open enrollment program. While boilerplate section 1624 appears to appropriate an additional $20 million in tobacco settlement dollars if federal dollars do not materialize the additional dollars would only be available if the state budget director certifies the funds are available to finance this appropriation.

11.Q. Homeland Security continues to be a top priority. A number of states have revised their public health codes to assure that public health officials have sufficient authority to carry-out their responsibilities during public health emergencies. Does the Michigan Public Health Code need to be revised to assure that it serves homeland security? What role should the department play during a state of emergency?

11. An initial review of Michigan statutes after September 11, 2001, revealed that Michigan law is sufficient to handle any public health emergency. Between the Emergency Management Act and provisions of the Public Health Code, Michigan has a strong set of laws that give broad authority to state and local officials during a crisis or emergency. While it is not necessary to make major revisions, it is important to conduct an ongoing review of these laws to ensure that our state and local agencies are properly prepared to respond to public health emergencies.

As part of the CDC grant for bioterrorism preparedness, Michigan is conducting a thorough review of our statutes in comparison to the Model State Emergency Powers Act that has been developed to ensure a state has the proper legal framework to handle an

emergency situation. The Office of Public Health Preparedness is conducting this review, in cooperation with the Public Health Code Committee of the Michigan Association for Local Public Health. This task will result in a "gap analysis" between Michigan's current law and the proposed Model Statute.

To date, the following areas have been identified as requiring more work and analysis to determine if the statute should be changed:

1. 418.301 -- Workers' Compensation -- We will be working with the Department of Consumer and Industry Services to review the Workers' Disability Compensation Act to determine if it is appropriate to add an adverse reaction to a smallpox vaccination given to an employee as part of their employment and as directed by the President or a designated cabinet member, to the definition of "personal injury or work related disease."

2. The Michigan State Police have a concern about law enforcement's lack of authority to detain individuals in a public health emergency. While the Public Health Code does give this type of authority to the department and local health departments under our broad powers, law enforcement does not have authority to detain individuals under these circumstances. It is important to ensure that any extension of police power along these lines can only be done as a result of a request from health officials. We will be working with the Michigan State Police to see whether legislation is necessary.

3. 333.5207 -- Hazardous Communicable Disease -- Court Order to Enforce Warning Notice -- Current law does not allow the State Police to enforce a circuit court order. We will be working with the Michigan State Police to see whether it is appropriate for them to be allowed to enforce a court order issued under this section by the Circuit Court.

In addition, two areas of the Public Health Code have been identified by the department for immediate action:

1. Amend 333.9203 -- Mass Immunizations -- Ensure that health professionals are covered by liability protections when they are implementing a state-directed mass immunization program. Current statute provides protection only when health care workers are unpaid or are paid governmental staff who are "required" to participate.

2. Amend 333.9207-- Childhood Immunization Registry -- To utilize this registry system for smallpox vaccination surveillance, it is essential to remove age limitation.